



ORTHODONTIC INFORMATION
MEDICAL ASSISTANCE ADMINISTRATION/DIVISION OF MEDICAL MANAGEMENT
AUTHORIZATIONS - ORTHO
PO BOX 45506
OLYMPIA WA 98504-5506

Both Sides Of This Form Must be Completed and Submitted BEFORE Treatment.

PROVIDER NAME	PATIENT'S NAME	LAST	FIRST	MI	SEX
PROVIDER ADDRESS	PATIENT IDENTIFICATION CODE (PIC)				
DSHS Provider number:	FI	MI	DATE OF BIRTH	LAST NAME	TB

PART I. TREATMENT REQUESTED (Check box below)

- | | | |
|---|---|--|
| <input type="checkbox"/> Maxillo-facial cleft deformity | <input type="checkbox"/> Interceptive treatment | DATE REQUESTED: |
| <input type="checkbox"/> Full Treatment | <input type="checkbox"/> Limited Transitional Treatment
(mid-late mixed dentition) | <input type="checkbox"/> Advisory (If there is no request for treatment or appliances stop here) |
| <input type="checkbox"/> Transfer case | <input type="checkbox"/> Special Review | |

PREVIOUS TREATMENT PLAN? Yes No ESTIMATED START DATE

TENTATIVE TREATMENT PLAN:

FUNCTIONAL CONCERNs:

TREATMENT PLAN (Following Case Study):

(There should be no other equally effective, more conservative and substantially less costly treatment available.)

THIS SECTION FOR MAA/DUS USE ONLY

- Orthodontic case study and treatment request are authorized.
 Orthodontic case study request authorized. Requested treatment is not authorized at this time.
Submit case study for evaluation.

APPROVED

DENIED

PENDED

Refer to the cover sheet for the consultant's comments

Authorization Number:

Orthodontic Consultant

Date

The authorization number must be entered on all billings and extension requests.

RETAIN this information sheet with case record.

RETURN a copy of this form to Orthodontic Authorization, QUS - Dental (address at top of form) with request(s) for extension of authorization.
Direct Authorization Questions to (360) 725-1671

ORTHODONTIC DIAGNOSTIC INFORMATION

PART II

Client Name:		BRIEF INITIAL OPINIONS					
Client Age:		HABITS:					
Client's Chief Complaint:							
STAGE OF DENTITION: <input type="checkbox"/> Primary <input type="checkbox"/> Permanent <input type="checkbox"/> Mixed		MUSCULATURE: TONE & FUNCTION:					
ANTERIOR TEETH: Overjet _____ mm Overbite _____ mm Open bite _____ mm Midline _____ mm Crossbite _____		SYMMETRY of ARCHES:					
POSTERIOR TEETH: <u>Angle Classification:</u> Skeletal Classification: (Check One) <input type="checkbox"/> Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 Dental Classification: (Check One) Right: <input type="checkbox"/> Class 1 <input type="checkbox"/> E to E <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 Left: <input type="checkbox"/> Class 1 <input type="checkbox"/> E to E <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 <u>Cross bite:</u> Indicate all teeth involved _____		TEMPOROMANDIBULAR DYSFUNCTION:					
ANTERIOR CROWDING (Approximate) SPACING <table style="margin-left: auto; margin-right: auto;"><tr><td style="border: 1px solid black; width: 50px; height: 15px;"></td><td style="border: 1px solid black; width: 50px; height: 15px;"></td></tr><tr><td style="border: 1px solid black; width: 50px; height: 15px;"></td><td style="border: 1px solid black; width: 50px; height: 15px;"></td></tr></table>						ORAL HYGIENE: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
MISSING & MALPOSED TEETH (List) Ectopic Eruption (Numbers of teeth excluding 3rd Molar(s)): _____		Yes _____	RESTORATION OR CARIES PROBLEMS:				
Missing: _____		? _____	OTHER MEDICAL OR DENTAL PROBLEMS:				
Malposed, Inclined, or Rotated: _____		_____					
Impacted _____		_____					
Ankylosed _____		_____					
Supernumerary _____		_____					
Malformed _____		_____					
I certify that the information provided is true and accurate to the best of my knowledge.							
PROVIDER SIGNATURE			DATE				